



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER OF PLANO
10030 N MACARTHUR SUITE 100
IRVING TX 75063

Carrier's Austin Representative Box

19

Respondent Name

FIDELITY & GUARANTY INSURANCE

MFDR Date Received

JANUARY 6, 2012

MFDR Tracking Number

M4-12-1505-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the Table of Disputed Services: "Review For Med Necessity Pre Cert was with Health insurance carrier"

Amount in Dispute: \$45,048.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The treatment involved a multi-day inpatient stay. Inpatient stays require preauthorization, and the requestor did not contact the carrier to seek and obtain preauthorization. The requestor alleges it contacted and obtained preauthorization from the claimant's group health insurer, United Healthcare. However, the requestor has provided no evidence of the same. Further, the requestor was required to seek preauthorization from the workers' compensation carrier, not the group health insurer, and even if preauthorization was obtained from the group health insurer, this does not relieve the requestor of the need to seek preauthorization from the workers' compensation carrier. Rule 134.600(f) requires preauthorization from *the* carrier, not a carrier. Emphasis added. Because the requestor failed to contact the workers' compensation carrier and obtain preauthorization, no reimbursement is due from the workers' compensation carrier."

Response Submitted by: Flahive Ogden & Latson, P. O. Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011 Through March 22, 2011	Inpatient Hospital Surgical Services	\$45,048.80	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for

inpatient services.

3. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. The services in dispute were reduced/denied by the claimant's commercial insurance carrier with the following reason codes:

Explanation of benefits dated April 19, 2011

- (D2) – THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.
- (56) – ACCORDING TO OUR RECORDS, THE OUT OF POCKET MAXIMUM AMOUNT HAS BEEN REACHED FOR THIS PLAN YEAR.
- (#) – PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

The services in dispute were reduced/denied by the claimant's workers' compensation insurance carrier with the following reason codes:

Explanation of benefits dated September 22, 2011

- 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

Explanation of benefits dated October 31, 2011

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- Refer to Workers' Compensation jurisdiction disclaimer paragraph (38) on reverse.

Issues

1. Is the requestor's preauthorization approval from the claimant's commercial insurance carrier relevant in the claimant's workers' compensation dispute?
2. Did the requestor obtain preauthorization approval from the claimant's workers' compensation insurance carrier prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor sought and obtained preauthorization approval from the claimant's commercial insurance prior to rendering the disputed services. However, review of the submitted information finds insufficient documentation to support that the requestor sought and obtained preauthorization approval from the claimant's appropriate workers' compensation insurance carrier prior to rendering the disputed services. The division finds that the requestor's preauthorization approval from the claimant's commercial insurance is not relevant to this dispute.
2. Per Texas Labor Code, Section §413.011(d) "the [workers' compensation] insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) and (r)...only when the following situations occur...preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(1) requires preauthorization of "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.."
3. Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization was obtained by the claimant's workers' compensation insurance carrier for the inpatient hospital surgical services performed from March 16, 2011 through March 22, 2011. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	December 20, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.